Senate

General Assembly

File No. 357

January Session, 2007

Substitute Senate Bill No. 1425

Senate, April 5, 2007

The Committee on Human Services reported through SEN. HARRIS of the 5th Dist., Chairperson of the Committee on the part of the Senate, that the substitute bill ought to pass.

AN ACT CONCERNING MANAGED CARE ORGANIZATIONS CONTRACTING WITH THE DEPARTMENT OF SOCIAL SERVICES.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Section 17b-296 of the general statutes is amended by adding subsection (e) as follows (*Effective from passage*):

(NEW) (e) All contracts between the department and a managed care organization to provide services under the HUSKY Plan, Part A, the HUSKY Plan, Part B, or both, or the Medicaid program, and all documents maintained by a managed care organization related to the performance of its contracts with the department, including, but not limited to, contracts and agreements with providers and subcontractors, documents concerning rates paid to providers and subcontractors, and documents concerning operational standards, shall be deemed public records or files as defined in section 1-200 and shall be subject to disclosure in accordance with chapter 14.

Sec. 2. Section 1-218 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

Each contract in excess of two million five hundred thousand dollars between a public agency and a person for the performance of a governmental function shall (1) provide that the public agency is entitled to receive a copy of records and files related to the performance of the governmental function, and (2) indicate that such records and files are subject to the Freedom of Information Act and may be disclosed by the public agency pursuant to the Freedom of Information Act. Any contract between the Department of Social Services and a managed care organization to provide services under the HUSKY Plan, Part A, the HUSKY Plan, Part B, or both, or the Medicaid program, irrespective of whether such contract is in excess of two million five hundred thousand dollars, shall be subject to the provisions of this section. No request to inspect or copy such records or files shall be valid unless the request is made to the public agency in accordance with the Freedom of Information Act. Any complaint by a person who is denied the right to inspect or copy such records or files shall be brought to the Freedom of Information Commission in accordance with the provisions of sections 1-205 and 1-206.

Sec. 3. Subdivision (11) of section 1-200 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(11) "Governmental function" means the administration or management of a program of a public agency, which program has been authorized by law to be administered or managed by a person, where (A) the person receives funding from the public agency for administering or managing the program, (B) the public agency is involved in or regulates to a significant extent such person's administration or management of the program, whether or not such involvement or regulation is direct, pervasive, continuous or day-to-day, and (C) the person participates in the formulation of governmental policies or decisions in connection with the administration or management of the program and such policies or decisions bind the public agency. "Governmental function" includes the provision of services by a managed care organization under the

HUSKY Plan, Part A, the HUSKY Plan, Part B, or the Medicaid program. "Governmental function" **[**shall**]** does not include the mere provision of goods or services to a public agency without the delegated responsibility to administer or manage a program of a public agency.

Sec. 4. Section 17b-28 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2007*):

(a) There is established a council which shall advise the Commissioner of Social Services on the planning and implementation of a system of Medicaid managed care and shall monitor such planning and implementation and shall advise the Waiver Application Development Council, established pursuant to section 17b-28a, on matters including, but not limited to, eligibility standards, benefits, access and quality assurance. The council shall be composed of the chairpersons and ranking members of the joint standing committees of the General Assembly having cognizance of matters relating to human services, public health and appropriations and the budgets of state agencies, or their designees; two members of the General Assembly, one to be appointed by the president pro tempore of the Senate and one to be appointed by the speaker of the House of Representatives; the director of the Commission on Aging, or a designee; the director of the Commission on Children, or a designee; the Healthcare Advocate, or a designee; two community providers of health care, to be appointed by the president pro tempore of the Senate; two representatives of the insurance industry, to be appointed by the speaker of the House of Representatives; two advocates for persons receiving Medicaid, one to be appointed by the majority leader of the Senate and one to be appointed by the minority leader of the Senate; one advocate for persons with substance abuse disabilities, to be appointed by the majority leader of the House of Representatives; one advocate for persons with psychiatric disabilities, to be appointed by the minority leader of the House of Representatives; two advocates for the Department of Children and Families foster families, one to be appointed by the president pro tempore of the Senate and one to be appointed by the speaker of the House of Representatives; two

members of the public who are currently recipients of Medicaid, one to be appointed by the majority leader of the House of Representatives and one to be appointed by the minority leader of the House of Representatives; two representatives of the Department of Social Services, to be appointed by the Commissioner of Social Services; two representatives of the Department of Public Health, to be appointed by the Commissioner of Public Health; two representatives of the Department of Mental Health and Addiction Services, to be appointed by the Commissioner of Mental Health and Addiction Services; two representatives of the Department of Children and Families, to be appointed by the Commissioner of Children and Families; two representatives of the Office of Policy and Management, to be appointed by the Secretary of the Office of Policy and Management; one representative of the office of the State Comptroller, to be appointed by the State Comptroller and the members of the Health Care Access Board who shall be ex-officio members and who may not designate persons to serve in their place. The council shall choose a chair from among its members. The joint committee on Legislative Management shall provide administrative support to such chair. The council shall convene its first meeting no later than June 1, 1994.

(b) The council shall make recommendations concerning (1) guaranteed access to enrollees and effective outreach and client education; (2) available services comparable to those already in the Medicaid state plan, including those guaranteed under the federal Early and Periodic Screening, Diagnostic and Treatment Services Program under 42 USC 1396d; (3) the sufficiency of provider networks; (4) the sufficiency of capitated rates provider payments, financing and staff resources to guarantee timely access to services; (5) participation in managed care by existing community Medicaid providers; (6) the linguistic and cultural competency of providers and other program facilitators; (7) quality assurance; (8) timely, accessible and effective client grievance procedures; (9) coordination of the Medicaid managed care plan with state and federal health care reforms; (10) eligibility levels for inclusion in the program; (11) cost-sharing provisions; (12) a benefit package; (13) coordination with coverage under the HUSKY

Plan, Part B; (14) the need for program quality studies within the areas identified in this section and the department's application for available grant funds for such studies; (15) managed care portion of the state-administered general assistance program; and (16) other issues pertaining to the development of a Medicaid Research and Demonstration Waiver under Section 1115 of the Social Security Act.

(c) The Commissioner of Social Services shall seek a federal waiver for the Medicaid managed care plan. Implementation of the Medicaid managed care plan shall not occur before July 1, 1995.

(d) Not later than January 1, 2008, and annually thereafter, the Commissioner of Social Services shall report to the council on: (1) Any sanction imposed by the department on a managed care organization with whom the department contracts for administration of the HUSKY Plan, Part A and Part B, and (2) any information received from a managed care organization pursuant to subsection (e) of this section. The report shall include the reasons for the imposition of any sanction and any penalty, including, but not limited to, a financial penalty, imposed on a managed care organization as the result of any sanction. The initial report from the department shall report on any sanctions imposed during the time period from January 1, 2000, to June 30, 2007. Annual reports thereafter shall include data on sanctions imposed in subsequent calendar years.

(e) Not later than July 1, 2008, and annually thereafter, any managed care organization with whom the department contracts for administration of the HUSKY Plan, Part A and Part B, shall report to the department on the application of such organization's annual rate adjustment received during the previous fiscal year to subcontracted services, including, but not limited to, dental, vision and pharmacy services.

[(d)**]** (f) The Commissioner of Social Services shall provide monthly reports on the plans and implementation of the Medicaid managed care system to the council.

[(e)**]** (g) The council shall report its activities and progress once each quarter to the General Assembly.

Sec. 5. Section 17b-274 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2007*):

(a) The Division of Criminal Justice shall periodically investigate pharmacies to ensure that the state is not billed for a brand name drug product when a less expensive generic substitute drug product is dispensed to a Medicaid recipient. The Commissioner of Social Services shall cooperate and provide information as requested by such division.

(b) A licensed medical practitioner may specify in writing or by a telephonic or electronic communication that there shall be no substitution for the specified brand name drug product in any prescription for a Medicaid, state-administered general assistance **[**,**]** or ConnPACE recipient, provided (1) the practitioner specifies the basis on which the brand name drug product and dosage form is medically necessary in comparison to a chemically equivalent generic drug product substitution, and (2) the phrase "brand medically necessary" shall be in the practitioner's handwriting on the prescription form or, if the prohibition was communicated by telephonic communication, in the pharmacist's handwriting on such form, and shall not be preprinted or stamped or initialed on such form. If the practitioner specifies by telephonic communication that there shall be no substitution for the specified brand name drug product in any prescription for a Medicaid, state-administered general assistance **[**,**]** or ConnPACE recipient, written certification in the practitioner's handwriting bearing the phrase "brand medically necessary" shall be sent to the dispensing pharmacy within ten days. A pharmacist shall dispense a generically equivalent drug product for any drug listed in accordance with the Code of Federal Regulations Title 42 Part 447.332 for a drug prescribed for a Medicaid, state-administered general assistance **[**,**]** or ConnPACE recipient unless the phrase "brand medically necessary" is ordered in accordance with this subsection and

such pharmacist has received approval to dispense the brand name drug product in accordance with subsection (c) of this section.

(c) The Commissioner of Social Services shall implement a procedure by which a pharmacist shall obtain approval from an independent pharmacy consultant acting on behalf of the Department of Social Services, under an administrative services only contract, whenever the pharmacist dispenses a brand name drug product to a Medicaid, state-administered general assistance **[**,**]** or ConnPACE recipient and a chemically equivalent generic drug product substitution is available. The length of authorization for brand name drugs shall be in accordance with section 17b-491a. In cases where the brand name drug is less costly than the chemically equivalent generic drug when factoring in manufacturers' rebates, the pharmacist shall dispense the brand name drug. If such approval is not granted or denied within two hours of receipt by the commissioner of the request for approval, it shall be deemed granted. Notwithstanding any provision of this section, a pharmacist shall not dispense any initial maintenance drug prescription for which there is a chemically equivalent generic substitution that is for less than fifteen days without the department's granting of prior authorization, provided prior authorization shall not otherwise be required for atypical antipsychotic drugs if the individual is currently taking such drug at the time the pharmacist receives the prescription. The pharmacist may appeal a denial of reimbursement to the department based on the failure of such pharmacist to substitute a generic drug product in accordance with this section.

(d) In all cases where a Medicaid, state-administered general assistance or ConnPACE recipient presents to a pharmacist a prescription for a drug requiring prior approval, but for which prior approval has not been obtained by such recipient, the Department of Social Services or any entity that administers a Medicaid managed care health plan shall:

(1) Ensure the immediate electronic authorization of up to a fifteen-

day supply of the originally prescribed drug and require that the initial response to a pharmacist requesting authorization for the drug include confirmation of the availability of payment for dispensing such a temporary supply;

(2) Ensure that contemporaneous written notification, in a format that has been developed and created by the department or such entity is provided by the pharmacy to such recipient that (A) informs the recipient that the drug may be covered but that prior approval from the prescriber is first required in order to obtain the prescribed drug, and (B) instructs such recipient that he or she should contact their prescriber to obtain such prior approval; and

(3) Provide notification to the prescriber, not later than twenty-four hours after receipt of the prescription by the pharmacy, by facsimile transmission, telephone or electronic mail, that prior approval is required in order for the recipient to receive the prescribed drug.

[(d)**]** (e) A licensed medical practitioner shall disclose to the Department of Social Services or such consultant, upon request, the basis on which the brand name drug product and dosage form is medically necessary in comparison to a chemically equivalent generic drug product substitution. The Commissioner of Social Services shall establish a procedure by which such a practitioner may appeal a determination that a chemically equivalent generic drug product substitution is required for a Medicaid, state-administered general assistance, or ConnPACE recipient.

Sec. 6. (NEW) (*Effective July 1, 2007*) Not later than January 1, 2008, the Department of Social Services shall hire a medical director, whose prescribed duties shall include, but not be limited to, determinations as to which services qualify as being medically necessary for each medical assistance program administered by the department.

Sec. 7. (NEW) (*Effective July 1, 2007*) (a) Notwithstanding any provision of the general statutes, not later than January 1, 2008, the Department of Social Services shall develop and implement a pilot

program for the delivery of health care services through a system of primary care case management. The pilot program shall be implemented in one or more geographic areas of the state as determined by the Commissioner of Social Services. Participation in the pilot program shall be on a voluntary basis. The pilot program shall allow not less than ten thousand individuals who are otherwise eligible to receive HUSKY Plan, Part A or HUSKY Plan, Part B benefits to receive such benefits through the primary care case management system. Two-thirds of the enrollees in the pilot program shall be children under the age of nineteen. For purposes of this section, "primary care case management" means a system of care in which the health care services for program beneficiaries are coordinated by a primary care provider chosen by or assigned to the beneficiary. "Primary care case management" does not include capitation payment system for medical services provided.

(b) Primary care providers participating in the primary care case management system shall be reimbursed by the state for medical services provided and for health care coordination services provided on behalf of program beneficiaries. Primary care providers shall provide beneficiaries with primary care medical services and arrange for specialty care as needed. The network of primary care providers utilized by the department shall include health care professionals employed at community health centers and school-based health clinics.

(c) The Department of Social Services may contract with an administrative services organization to coordinate the availability of services under the primary care case management pilot program. In addition, the department may directly contract with any medical provider or group of medical providers in order to facilitate implementation of the primary care case management pilot program. The department when selecting an entity to administer the primary care case management pilot program may not select any managed care organization, subsidiary of, affiliate of or any related company within the control of the managed care organization currently under contract with the department for the provision of managed care.

(d) Any program beneficiary who elects to enroll in the primary care case management pilot program shall be afforded the option of seeking a change of primary care provider which shall be determined by the department on a case-by-case basis.

(e) The department shall ensure that a beneficiary that elects to participate in the primary case management pilot program has access to dental services and behavioral health services as part of the program.

(f) The department shall provide monthly reports on the progress in planning and developing the primary care case management pilot program to the council established pursuant to section 17b-28 of the general statutes, as amended by this act. In addition, not later than six months after the date of implementation of the primary care case management pilot program and annually thereafter, the department shall conduct a comprehensive review of the program that includes costs, beneficiary satisfaction surveys, provider satisfaction surveys, access and utilization reports, administrative efficiency reports and recommendations for improvement of the pilot program, and after completing such review, the department shall submit a written report on the results to said council.

(g) The Commissioner of Social Services may amend the Medicaid state plan or seek a waiver from federal law, if necessary, in order to implement the primary care case management pilot program in accordance with the provisions of this section.

(h) The commissioner, pursuant to section 17b-10 of the general statutes, may implement policies and procedures to administer the provisions of this section while in the process of adopting such policies and procedures as regulation, provided the commissioner prints notice of the intent to adopt the regulation in the Connecticut Law Journal not later than twenty days after the date of implementation. Such policy shall be valid until the time final regulations are adopted.

Sec. 8. (NEW) (*Effective July 1, 2007*) The Department of Social

Services, in collaboration with the council established pursuant to section 17b-28 of the general statutes, as amended by this act, shall develop a pay-for-performance system that rewards a managed care organization with whom the department contracts for the provision of services to HUSKY Plan, Part A and Part B beneficiaries for superior performance in beneficiary satisfaction, provider access and satisfaction and overall beneficiary health outcomes. The department and the council shall ensure that there is public input on the development of such system. The department after receiving such public input shall develop standards to be used in determining whether a managed care organization is eligible for a pay-for-performance bonus payment. Pay-for-performance bonus payments shall only be made when the department determines that a managed care organization has met or surpassed all standards established by the department. If no managed care organization meets the department's standards then no bonus payment shall be made. Any bonus payment shall come from the department's capitation payments to managed care organizations and shall not result in additional appropriations to the department to make such payment. Any plan developed by the department in collaboration with the council shall not be implemented unless approved by the General Assembly.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*from passage*	17b-296
Sec. 2	*from passage*	1-218
Sec. 3	*from passage*	1-200(11)
Sec. 4	*July 1, 2007*	17b-28
Sec. 5	*July 1, 2007*	17b-274
Sec. 6	*July 1, 2007*	New section
Sec. 7	*July 1, 2007*	New section
Sec. 8	*July 1, 2007*	New section

HS *Joint Favorable Subst.*

The following fiscal impact statement and bill analysis are prepared for the benefit of members of the General Assembly, solely for the purpose of information, summarization, and explanation, and do not represent the intent of the General Assembly or either chamber thereof for any purpose:

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect
Department of Social Services	GF - See Below

Municipal Impact: None

Explanation

This bill makes numerous changes to the Department of Social Services' (DSS) HUSKY managed care programs.

Sections 1 through 3 of the bill make managed care contracts subject to Freedom of Information policies. This change is not expected to have a direct fiscal impact on the state.

Section 4 changes the membership of the Medicaid Managed Care Council and requires DSS to report additional information to the council. These changes are not expected to have a direct fiscal impact on the state.

Section 5 requires the HUSKY managed care organizations (MCO's) to provide a minimum temporary supply of drugs when prior authorization has not been obtained. This stipulation is not expected to have any fiscal impact as the HUSKY MCO's already have such procedures in place.

Section 6 of the bill requires DSS to hire a medical director by January 1, 2008. The bill does not specify the qualifications for the position. It is estimated that such a position would have an annual salary in the range of $125,000 to $150,000, not including fringe benefit

costs.[1]

Section 7 requires DSS to establish a primary care case management (PCCM) pilot for at least 10,000 HUSKY clients. The bill requires DSS to reimburse providers in this pilot for any medical and health care coordination services. The bill specifies that the PCCM not utilize a capitated payment system. DSS may contract with an administrative service organization (ASO) to coordinate the PCCM.

Under the current managed care system, DSS provides a capitated payment to the MCO's for each HUSKY client. The MCO's bear the risk for any costs which exceed their capitated payment. Under this system, annualized costs for 10,000 clients would be approximately $25,700,000.

The bill does not require the PCCM ASO to bear any risk for the cost of services provided to the HUSKY clients, nor to provide any utilization review. The ASO further has no incentive to negotiate rates paid to hospitals or other providers. Therefore, it is likely that the per-person cost under a PCCM model will exceed that under the current capitated model. The extent of this increase is not known. For purposes of illustration, a 5% increase in costs for the 10,000 person pilot would require an additional $1.3 million annually.

The bill does not specify what entity is to be responsible for meeting federal and state reporting requirements under the PCCM system. It is not clear whether federal reimbursement can be received for services provided without such reporting.

The bill includes additional review reporting requirements for DSS

[1] The fringe benefit costs for state employees are budgeted centrally in the Miscellaneous Accounts administered by the Comptroller. The estimated first year fringe benefit rate for a new employee as a percentage of average salary is 25.8%, effective July 1, 2006. The first year fringe benefit costs for new positions do not include pension costs. The state's pension contribution is based upon the prior year's certification by the actuary for the State Employees Retirement System (SERS). The SERS 2006-07 fringe benefit rate is 34.4%, which when combined with the non pension fringe benefit rate totals 60.2%.

concerning the PCCM that will result in increased administrative costs to the department.

Section 8 of the bill establishes a pay-for-performance system for the HUSKY MCO's. The bill specifies that any bonuses must come from current capitated payments and must not result in any additional appropriations. Under this system, MCO's would be rewarded based on beneficiary satisfaction and health outcomes, as well as provider access and satisfaction. It is not clear that the factors upon which the rewards are to be based will necessarily result in savings to the system. Therefore, it is uncertain whether there would be funds available within the capitated system to make such rewards.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to inflation.

OLR Bill Analysis

sSB 1425

AN ACT CONCERNING MANAGED CARE ORGANIZATIONS CONTRACTING WITH THE DEPARTMENT OF SOCIAL SERVICES.

SUMMARY:

This bill makes a number of changes in how the Department of Social Services (DSS) delivers, and is accountable for, health care services the law requires it to provide. Specifically, it:

1. makes the performance of HUSKY managed care contracts a governmental function under the Freedom of Information Act (FOIA), regardless of the value of the contract;

2. requires HUSKY managed care organizations (MCO) to report on how they pass along rate adjustments to subcontracting service providers;

3. requires DSS to report on sanctions it imposes on the HUSKY MCOs;

4. requires the department to develop and implement a voluntary primary care case management (PCCM) pilot program for at least 10,000 HUSKY recipients;

5. requires the department to develop a pay-for-performance system to reward HUSKY MCOs that meet certain performance benchmarks; and

6. specifies the minimum temporary supply of drugs that pharmacists must dispense when prior authorization (PA) for drugs dispensed under DSS' pharmacy assistance programs has not been obtained, and directs the entity administering the drug program to take certain actions when this occurs.

By January 1, 2008, the bill requires DSS to hire a medical director, whose duties must include, at a minimum, determining which services qualify as being medically necessary for each medical assistance program DSS runs.

Finally, the bill adds the Healthcare Advocate, or his designee, to the Medicaid Managed Care Council, which oversees the HUSKY and SAGA medical assistance programs.

EFFECTIVE DATE: July 1, 2007, except the FOIA provisions are effective upon passage.

MEDICAID MANAGED CARE MCOS DISCLOSURE OF RECORDS

DSS Contracts and FOIA

The bill requires that certain language be included in contracts, and related documents, between the department and managed care organizations serving individuals receiving HUSKY A or B or other Medicaid benefits. The bill specifies that the contracts and documents include (1) contracts and agreements with providers and subcontractors, (2) documents concerning rates paid to them, and (3) documents concerning operational standards. The requirement applies to contracts of any value.

The bill includes MCOs providing services to HUSKY or other Medicaid beneficiaries in the definition of a governmental function. Thus, the contracts must (1) entitle DSS to copies of records and files related to the contract's performance and (2) indicate that the records and files are subject to disclosure under FOIA. Anyone denied access to the records or files must first file a complaint with the Freedom of Information Commission.

REPORTS ON RATE ADJUSTMENTS AND SANCTIONS IMPOSED ON MCOS

By July 1, 2008 and annually thereafter, the bill requires any MCO contracting with the department under HUSKY A or B to report to DSS on how it applies any annual rate adjustment it received during the previous fiscal year to subcontracted services, including at a minimum

dental, vision, and pharmacy. DSS pays MCOs monthly payments to provide all HUSKY A- and B-covered services to program enrollees.

The bill also requires the DSS commissioner, beginning January 1, 2008 and annually thereafter, to report to the Medicaid Managed Care Council on (1) any sanction it imposed on a HUSKY MCO and (2) any information it receives from MCOs regarding the subcontracted services. The report must include the reasons for imposing the sanction and any penalty, including a financial one. The first report must include sanctions imposed between January 1, 2000 and June 30, 2007. Subsequent reports must include data on sanctions imposed in subsequent calendar years. (This appears to omit any sanctions imposed between July 1, 2007 and December 31, 2007.)

PRIMARY CARE CASE MANAGEMENT (PCCM)

By January 1, 2008, the department must develop and implement a PCCM program for at least 10,000 HUSKY A or B recipients. The voluntary pilot must be implemented in at least one geographic area of the state that the DSS commissioner determines. Two-thirds of the pilot enrollees must be children under the age of 19. The bill defines PCCM as a system of care in which health care services are coordinated by a primary care provider (PCP) assigned to, or chosen by, the program beneficiary. It does not include a capitation payment system. Currently, HUSKY A and B is a capitated health care system in which DSS pays a monthly capitated rate to MCOs for each HUSKY participant enrolled in that MCO, and the MCO is expected to provide all the HUSKY-covered health services the enrollee receives.

Participating PCPs must be reimbursed for any medical services provided and for health care coordination they provide to PCCM enrollees. The PCPs must provide the enrollees primary care services and arrange for specialty care as needed. The network of PCPs the department uses must include health care professional employed at community health centers and school-based health clinics. (The bill does not require DSS to establish a network.)

The bill permits the deparment to contract with an administrative services organization (ASO) to coordinate the availability of services under the pilot. And it may contract directly with any medical provider or group of providers to facilitate the pilot's implementation. When selecting the entity to administer the pilot (which, presumably is the ASO), DSS may not select any MCO, subsidiary of, affiliate of, or any related company within the control of the MCO currently under contract with DSS to serve the HUSKY population.

Anyone enrolling in the pilot must be given the option of changing his or her PCP, which DSS determines on a case-by-case basis.

The bill requires DSS to ensure that pilot enrollees have access to dental and behavioral health services, which must be part of the pilot.

The bill requires DSS to provide monthly reports on its progress in planning and developing the pilot to the Medicaid Managed Care Council. And no later than six months after the pilot begins, and annually thereafter, DSS must conduct a comprehensive review of the pilot that includes costs, beneficiary and provider satisfaction surveys, access and utilization reports, administrative efficiency reports, and recommendations for improvements. Once the review is complete, the department must submit a report of its results to the council.

The bill permits the DSS commissioner to amend the Medicaid state plan or seek a federal waiver to implement the pilot. And he may implement policies and procedures to implement the program while in the process of adopting regulations, provided he publishes notice of intent in the *Connecticut Law Journal* within 20 days after implementation. The policy remains valid until final regulations are adopted.

PAY- FOR- PERFORMANCE (P4P) SYSTEM

The bill requires DSS, in collaboration with the Medicaid Managed Care Council, to develop a pay-for-performance (P4P) system that rewards a HUSKY MCO for superior performance in beneficiary satisfaction, provider access and satisfaction, and overall beneficiary

health outcomes. The two must ensure public input into developing the system.

Once input is given, DSS must develop standards to use in determining whether an MCO is eligible for a P4P bonus payment. Bonuses can be made only when the department determines that an MCO has met or surpassed the standards. If no MCO meets the standards, DSS does not pay any bonuses. Any bonus must come from DSS' capitation payments and cannot result in additional appropriations to the department.

The bill requires that any "plan developed by the department in collaboration with the council" cannot be implemented unless the General Assembly approves it. It is unclear but presumably, the plan refers to the P4P system.

DSS does not currently offer P4P to the HUSKY MCOs, but apparently some of the MCOs have their own programs. (DSS has received a federal P4P technical assistance planning grant.)

PRIOR AUTHORIZATION (PA) FOR PRESCRIPTION DRUGS

In general, when someone enrolled in any of DSS's pharmacy assistance programs (i.e., ConnPACE, Medicaid and State-Administered General Assistance (SAGA)) wishes to receive a brand-name drug when a chemically equivalent generic is available, the pharmacist dispensing the drug must get PA from an independent pharmacy consultant acting on DSS' behalf. In the HUSKY program, the MCOs use pharmacy benefit managers that have their own PA system. If PA is not granted or denied within two hours, the law deems it granted (see BACKGROUND for an explanation of how PA works, in practice).

The bill requires the department, or in the case of HUSKY A, the entity administering the MCO's pharmacy benefit, whenever a Medicaid, SAGA, or ConnPACE recipient presents a prescription requiring PA but the recipient has not obtained it, to take the following actions:

1. ensure the immediate electronic authorization of up to a 15-day supply of the originally-prescribed drug, and require that the initial response to a pharmacist requesting PA include confirmation of the availability of payment to the pharmacists for dispensing the temporary supply;

2. ensure that at the same time, the pharmacy notifies the recipient in writing, in a form that DSS or the entity develops, that (a) the drug may be covered but that PA is required for it to be obtained and (b) the recipient should contact his or her prescriber to obtain PA; and.

3. notify the prescriber via fax, telephone, or electronic mail, no later than 24 hours after the pharmacy receives the prescription, that PA is required for the drug to be dispensed.

FOIA, Governmental Function, HUSKY Managed Care, and Case Law

By law, whenever a state agency has a contract with a person to perform a governmental function and the contract is worth more than $2.5 million, the contract must (1) provide that the public agency is entitled to receive a copy of records and files related to the performance of the governmental function and (2) indicate that these records and files are subject to the FOIA and the agency can disclose them.

Governmental function is defined as the administration or management of a public agency's program, which program has been authorized by law to be administered or managed by a person where (1) the person receives funding from the public agency to do so; (2) the agency is involved in or regulates to a significant extent these activities, regardless of the degree; and (3) the person participates in formulating governmental policies or decisions in connection with the program's administration or management.

Over the last few years, academic researchers, health advocates, and others have tried to get information from the department on the four

MCOs currently serving the HUSKY A and B population, such as the number of specialists and the fees the MCOs pay for services rendered. In many instances, the information has been refused because the MCOs believe it is proprietary. Those seeking the information have attempted to get the information through an FOIA request, which the FOI commission has granted.

But the MCOs (except for WellCare) appealed to the Superior Court, which dismissed the appeals, as a group, in November 2006, in part concluding that the MCOs, for all intents and purpose, are performing a government function and therefore subject to the FOIA *(Health Net of Connecticut, et. al, vs. Freedom of Information Commission, Nos. CV 060401028S, CV 064010429S, CV 064010430S,, CV 064009521S; November 29, 2006).* The case is on appeal to the Supreme Court and is currently awaiting further articulation from the Superior Court judge.

Prior Authorization in Pharmacy Assistance Programs

Although the law deems PA granted if it is not granted or denied within two hours, in practice, it frequently takes longer for final decisions to approve or deny to be made, frequently because the prescriber cannot be reached within that time frame. While awaiting PA decisions, the pharmacists will often dispense a temporary supply of the requested drug. Once all the necessary information is obtained, the final decision to approve or deny the PA must be made.

Pharmacy benefits for certain children and adults (HUSKY A) are managed by the MCOs, while ConnPACE recipients who qualify for Medicare receive their pharmacy benefits through the Medicare Part D program. Both the HUSKY MCOs and the Medicare Part D plans have drug formularies and their own PA systems.

The HUSKY A contracts between the department and the MCOs call for a 30-day supply but the process for the supply ultimately to be authorized differs. (Apparently, one HUSKY MCO automatically grants a 30-day temporary supply for drugs requiring PA.) In ConnPACE, if a recipient needs a drug that is not on his or her Part D plan's formulary, the state will pay for it, and at present, there is no

further PA done by DSS' pharmacy contractor. An individual enrolled in the Medicaid fee-for-service program can receive a five-day temporary supply if the individual's prescriber has indicated to the pharmacist that PA is needed.

BACKGROUND

Related Bills

Several legislative committees have favorably reported bills broadly addressing health care access that contain provisions similar to those in sSB 1425. They are:

Bill Number	*Committee*
sSB 1	Public Health
sSB 3	Human Services
sSB 70	Insurance
SB 1127	Human Services
sSB 1371	Insurance
sHB 6158	Children
sHB 6652	Insurance
sHB 7314	Labor
sHB 7375	Human Services

sHB 7322, favorably reported by the Human Services Committee, contains some identical provisions related to the FOIA and MCOs, as well as provisions concerning PCCM, P4P, rebates, and medical necessity.

SB 1290, favorably reported by the Labor Committee, extends the definition of performing a governmental function to subcontractors.

COMMITTEE ACTION

Human Services Committee

Joint Favorable Substitute
Yea 19 Nay 0 (03/22/2007)